



from an eating disorder.

The book has several interesting and helpful touches, such as a “did you know” fact table every few pages [Did you know ... of those children with anorexia nervosa who are 13 years old or younger, approximately one in five are boys, four in five are girls (page 38)]. The book provides several worksheets for parents to complete and also contains a series of case studies. While the premise of the book is to facilitate parents’ ability to effectively cope with a child that has an eating disorder, there are several sections of the book that speak to teachers, friends and other family members. The book can be shared with these individuals to foster something of a community knowledge about eating disorders, helping to destigmatize the disease.

According to *Help for Eating Disorders*, approximately one in 10 individuals with child onset anorexia nervosa dies from the disease. A book such as this goes a long way in informing about signs of the disease, how to help individuals who have the disease and how to cope if you are a parent faced with the trauma of watching your child struggle with an eating disorder. This book is highly recommended—accolades and applause to the authors for responsibly educating the public about eating disorders.

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Children's Health Under Medicaid: A National Review of Early and Periodic Screening, Diagnosis and Treatment, 1999–2003

National Health Law Program Inc.; 164 pages

Children's Health Under Medicaid: A National Review of Early and Periodic Screening, Diagnosis and Treatment 1999–2003 is the third edition of *Children's Health Under Medicaid* by the National Health Law Program (NHeLP). NHeLP first published *Children's Health Under Medicaid: A National Review of Periodic Screening, Diagnosis and Treatment* in August 1998. This initial report provided national and state-based data from the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services reporting form (CMS-416) for federal fiscal years (FYs) 1994–1996. The second edition provided data from federal FYs 1997–1998. Form CMS-416 was significantly revised in 1999. This is the first report following these considerable revisions. NHeLP published a primer on the revisions for child advocates in 2003: *Measuring Preventive Health Performance: A Primer for Child Advocates on the Medicaid EPSDT Reporting Form*. The purpose of the current report is to provide the state and national Form-416 data from federal FYs 1999–2003 and to highlight the differences in the data and the reporting process since the form was revised in FY 1999.

Prior to reporting the national and state data, the authors provide an overview to the purpose of the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. The scope and reporting requirements of EPSDT are outlined in detail, and the 1999 revisions, which change the reporting requirements, are high-

lighted. The report highlights each of the changes in Form-416 and the implications of each of these changes on both state and national data. The national data profile is provided, using data taken directly from Form-416 and reported by Centers for Medicare & Medicaid Services. The state-based profiles, indicating: 1) number of children eligible in 2003, 2) number of children referred for corrective treatment in 2003, 3) number of children receiving any dental services in 2003, 4) percentage of children receiving any dental services in 2003, and 5) number of children receiving screening blood lead tests in 2003 are shown together. State-by-state summaries of Form-416 data for federal FYs 1999–2003 are shown, indicating the total number of eligible children and the participant rates. The allowance of different periodicity schedules from state to state does not permit charts indicating total number of eligible children to be uniformly scaled or compared across states. Additionally, for states where the reporting requirements were revised after FY 1999, it is difficult to determine the extent to which the performance of the state improved or deteriorated.

This report is an important critique of how the changes in Form-416 impact the accuracy of tracking EPSDT services. In 1990, the secretary of the Department of Health and Human Services set a goal that by FY 1995, each state should be providing ≥80% of EPSDT recipients with timely medical screens. Despite the fact that this goal has not been revised, the screening goals for each state have not been met, according to this most recent report. The report is able to demonstrate that individual states have not reached the secretary's goal; however, due to the change in reporting, state-to-state comparisons are not possible. The report provides an in-depth look at where changes in the EPSDT reporting form makes it impractic-

cal to make comparisons of data collected before and after FY 1999. Additionally, the report highlights important data, which, prior to FY 1999, was required but after FY 1999 is no longer provided. Furthermore, the purpose of this report ideally is to provide an accurate assessment of each state's compliance with all five of the mandatory age-appropriate components of the EPSDT medical screen. This comprehensive review details how the revised Form-416 fails to accomplish this basic goal. It is not the scope of this report or the reporting agency to provide solutions to the problems; however, the authors identify several adjustments to Form-416 or instructions which could have prevented these inaccuracies.

This report confirms that the consequences of the revisions to Form-416 are not insignificant. Due to the inability to accurately track each state's compliance with the mandatory components of the EPSDT medical screen, delivery of EPSDT services to eligible children may be incomplete and unreliable. According to NHeLP's report, the changes adopted in FY 1999 will allow states to exclude certain groups of children from reporting, adopt their own state-developed periodicity schedules (which may be different than prior to 1999) and assumes that all five of the mandatory components of the EPSDT medical screen have been provided. If the EPSDT program is to continue to positively impact the health of children living in poverty, participation and screening requires mandatory schedules, accurate tracking and close monitoring.

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Living with Diabetes: A Guide for Patients and Parents

*James W. Reed, MD and
Agiua Heath, MD; Chicago:
Hilton Publishing Co., 2005;
ISBN 0-9743144-0-4; 221 pages*

Diabetes mellitus is the most common endocrine disorder and the fifth leading cause of death in the United States. The condition affects more than 125,000 children in the United States, with approximately 13,000 new cases per year. Because more and more people are overweight, type-2 diabetes mellitus is increasingly common in both adults and children. In North America, type-2 diabetes mellitus comprises approximately 30% of all newly diagnosed cases in individuals 10–20 years of age.

This book is aimed primarily at diabetic patients and their parents. In this book, Reed and Heath educate readers on what diabetes is, how to recognize the symptoms, and how to manage the disease and reduce the risks. In this aim, the book succeeds admirably. Although the authors discuss both type-1 and type-2 diabetes mellitus, the emphasis is on type-2 diabetes mellitus. Lifestyle changes, such as healthy diet, regular physical exercise and losing extra weight, can lower the risk for developing diabetes mellitus. The aim of treatment of diabetes mellitus is the same regardless of the age of the patient and the type of diabetes mellitus: normalization of blood glucose and glycosylated hemoglobin (HbA_{1C}) levels without causing hypoglycemia. Target goals for blood glucose and HbA_{1C} levels must be attainable to achieve diabetes treatment adherence.

The book is divided into 14 chapters: "What is diabetes mellitus?," "Who gets diabetes?," "Diabetes in your child," "Dealing with your feeling," "Eating smart," "Get moving," "Hypoglycemia: the most common emergency situation," "Taking con-

trol of your health," "Working with health care providers," "Medication for diabetes," "All about insulin," "Long-term complications of diabetes," "Diabetes in pregnancy" and "Hope for the future." The appendix contains recipes recommended by the American Diabetes Association.

The strengths of this book are many. The book is user-friendly, uniquely organized and easily readable. It is written in a fresh and lively style. Medical terms are well explained. There are illustrative case histories in most chapters and summaries at the end of the chapters. In general, the information contained is appropriate, accurate and informative. The advice offered is generally sound, sensible and practical. The index is detailed.

The book has minor deficiencies. There are certain statements with which we do not agree. For example, "many people with type-2 diabetes have no symptoms at all." In our experience, people with type-2 diabetes have symptoms that may be overlooked. The authors define diabetes mellitus as "two fasting blood glucose levels ≥ 100 mg/dl or one random blood glucose level ≥ 180 mg/dl in someone with symptoms of diabetes." However, the American Diabetes Association defines diabetes mellitus as "a fasting plasma glucose ≥ 126 mg/dl or a random plasma glucose ≥ 200 mg/dl with symptoms of diabetes mellitus." The authors recommend that everyone with diabetes take a daily aspirin unless a medical condition prevents it. This advice is inappropriate for children, adolescents and even young adults for which the short-term risks of heart disease are not high enough to warrant this preventive measure. In addition, there are a number of notable omissions, including the potential protective effect of breastfeeding, neonatal diabetes, complications (poor growth—Mauriac syndrome, and joint and skin disorders) of and conditions (Somogyi phenomenon, dawn phenomenon, celiac disease